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THE ROLE OF STATE AND LOCAL GOVERNMENT IN HEALTH

by Drew E. Altman and Douglas H. Morgan

Prologue: As a consequence of the taxpayer’s revolt that began in California and spread across the country, sharp cutbacks in federal aid to subnational levels of government, and the economic recession, state and local governments are being forced to cope with dramatically reduced resources. Nevertheless, spending for health remains big business in state and local governments today. More than one of every six dollars states spend (16.9 percent) are devoted to health, slightly more than the share of the federal budget devoted to health (13 percent). Local governments spend 7.8 percent of their overall expenditures for health purposes, a proportion roughly equal to that of transportation, public safety, and natural resources and more than spending for public welfare. Recognizing that resources are shrinking at a time when responsibilities are expanding, Drew Altman and Douglas Morgan have a particular interest as officers at The Robert Wood Johnson Foundation in developing policy approaches to this difficult equation that spare the most vulnerable population segments of society. Altman, an assistant vice-president at the foundation, is a political scientist by training (Ph.D., Massachusetts Institute of Technology) and former health official in the Carter administration. Morgan, a senior program officer at the foundation who holds a master’s degree in public administration from New York University, was formerly the City of Newark’s director of public health. Two decades ago, Altman and Morgan would have been in the forefront of the Great Society, believing us they do in a strong central government. Now, realists that they are, Altman and Morgan are struggling, along with many others, to strike new balances, build new alliances, and make tough decisions in the face of limited resources. As they underscore, these judgments will involve incremental changes rather than fundamental funding reallocations or policy shifts. Despite the incremental nature of the shifts, though, it is unlikely that ever again will state and local governments be cast so easily as the adversaries of the poor—they now represent a vast resource to people without means.
Though responsibility for health care in the United States is, in unique fashion, both a public and private affair, in recent years, government—and most especially the federal government—has emerged as perhaps the single most important force shaping our health care system. This development has drawn attention to Washington and to what policymakers there are doing in health. Yet, as in other domestic policy areas, government’s role in health is shared. No level of government—federal, state, or local—has its own entirely autonomous sphere of action, and all three levels interact in shaping policy, in financing and delivering health care, and in running programs. Students of intergovernmental relations are familiar with Morton Grodzin’s now somewhat hackneyed metaphor for this state of affairs. The balance of government roles and responsibilities in America, he observed, looks much more like a marble cake than a layer cake with a clear separation of roles and functions.

However, despite the current preoccupation with events in Washington, increasingly we are seeing a rediscovery of the importance of the role of state and local governments in the health care field. Whether the issue is Medicaid, hazardous wastes, chemical spills, state rate setting or certificate-of-need, homeless persons on the streets of major cities, or lead paint poisoning, more and more attention is being focused on what state and local governments are doing in health. Several developments have spurred this apparent rediscovery of the state and local role, but three appear to be most noteworthy.

First, through his New Federalism initiatives, President Reagan has stimulated a fresh debate about the respective roles of each level of government in health as well as in other fields. This so-called New Federalism would substantially reshuffle the relationship between federal-state-local government, significantly expanding the role of the states in the governance and financing of domestic programs. President Reagan’s initiative has renewed awareness of important differences between liberals and conservatives on the respective roles of federal and state government—with liberals in recent years fearful of the motivations and capacities of state government, and conservatives equally fearful of any expansion of the federal purse or presence. The fate of the Medicaid program, among others, has been a hot issue in this larger debate.

Second, these are hard times for state and local governments. The tax revolt that began with Proposition 13, recent cutbacks in federal aid, and the nationwide economic recession have placed a severe burden on state and local governments. Their fiscal plight and their efforts to cope are receiving increasing attention, much of which has concentrated on the health area where state and local governments have been grappling with the problem of how to trim expenditures while still maintaining services and programs.

Third, and perhaps most important, in a period of belt-tightening and
retrenchment at all levels, both the general public and professionals in the health care field are concerned that these cutbacks might threaten the nation’s health. Over the past twenty years, this country has made truly significant gains in access to health care and in health. For example, the poor in the U.S. now see a physician and receive hospital care at least as often as the nonpoor, and such health status measures as mortality and morbidity and infant mortality have shown steady improvement. Though the evidence is not yet in one year or the other, there is now concern that the cutbacks that are being made threaten these gains. It is a concern that focuses not just on Washington, where broad financing and policy decisions are made, but at the state and local level as well, where the consequences of decisions are most visible and where services are actually delivered.

Thus, for philosophical, economic, and health care reasons, the role of state and local government in health is emerging both as an issue for professionals in the field and as a significant public issue as well.

The public officials who are the object of this attention face two broad challenges. The first is how to adapt, in the short term, to federal cutbacks and the pressures of today’s economy. In today’s economic climate, what choices and tradeoffs should state and local governments make in the health area? The second challenge involves the long-term role of state and local government in health. The fundamental question is whether state and local governments should refocus what they do in the health care field. Specifically, should more resources be invested in personal medical care or in public health, and what specific investments should be made in each area? Underlying these questions are historically difficult issues involving the role of the public and private sectors in health; the role of the different levels of government; and the adequacy of our knowledge base and the capacity of our political system for making tradeoff and priority decisions of this kind. The articles that follow address these challenges as well as these underlying concerns. As background, in this article we describe where things currently stand with regard to the state and local role in health.

The Evolution Of The State And Local Role

Broadly speaking, the health-related activities of state and local government are: traditional public health, including health monitoring, sanitation, and disease control; the financing and delivery of personal health services including Medicaid, mental health, and direct delivery through public hospitals and health departments; environmental protection, including protection against man-made environmental and occupational hazards; and the regulation of the providers of medical care through certificate-of-need and state rate setting as well as licensing and other functions. Though
we will not deal with these equally or comprehensively, a selective look at the history is useful in thinking about future roles and choices.

State and local government involvement in public health began with the great epidemics of the late eighteenth and early nineteenth centuries. The first of these, the yellow fever epidemic in Philadelphia, struck in 1793, and epidemics of cholera, smallpox, and yellow fever were frequent occurrences over the next fifty years. Initially, government responded to these epidemics by instituting quarantine measures and efforts to improve community sanitation. Generally these were directed by physicians appointed by the city or state government. Today we know that the causes of these epidemics were in large part social and economic. Counted among them were a rapidly growing and fast moving population; the urbanization of the Eastern seaboard which resulted in overcrowding, bad housing, inadequate sanitary facilities, polluted water supplies, and contaminated food; and the rapid expansion of the West, resulting in similar conditions on a smaller scale in new Western towns and communities.

However, the importance of these factors was not well understood in the early nineteenth century. Even when England and other countries were beginning to address these problems effectively, government in the United States was slow to respond. Due partly to the epidemics in Philadelphia, the nation’s capitol was moved from that city to Washington, D.C. in 1800.

At the local level in the early nineteenth century, a trend towards the full-time employment of persons to serve as the functional agents of local boards of health developed. This was the first step in the formation of local health departments. Health departments were established in Baltimore (1798), Charleston (1815), Philadelphia (1818), Providence (1832), and Cambridge (1846). But many cities did not establish separate public health agencies for some time. For example, New York City appointed its first inspector of health in 1804, but from 1810 to 1838 inspectors of health operated as a branch of the police department, sharing responsibility for health matters on a day-to-day basis with a state-appointed health officer (who was concerned mainly with the application of quarantine laws to vessels entering port) and a resident physician, usually a municipal official whose function was to be on the alert for cases of communicable disease within the city. In 1866, New York City formally established a central administration for health activities called the Metropolitan Board of Health. Other major cities—Chicago (1867), Louisville (1870), Indianapolis (1872), and Boston (1873)—did likewise.

Even with these early beginnings, public health in this nation did not begin to evolve as we know it today until the latter half of the nineteenth century. During this period two major events took place. The first was the publication of the Shattuck Report by the Massachusetts Sanitary Commission in 1850. Though today heralded as the Magna Carta of pub-
lic health, the Shattuck Report was not received with enthusiasm when it first appeared on the scene. The report was authored by Lemuel Shattuck of Boston, a bookseller and publisher who had become interested in public health through his activities in developing statewide registries for vital statistics. The Shattuck Report recommended the establishment of state health departments and of local boards of health in each town. In addition, it urged sanitary surveys of particular urban communities and other localities. It was not until some nineteen years later, however, that Massachusetts established its first state board of health. California followed a year later, and by the end of the century, thirty-eight other states had followed suit.

The other significant development—really a series of related developments—involved breakthroughs in the study of bacteria and the diseases they produce. By the late 1800s the discoveries of Pasteur and others had built a foundation of knowledge and technique for advances in the following decades that led ultimately to dramatic progress in the control of infectious diseases. Armed with this new science, health authorities began to act with greater discrimination in quarantine and environmental sanitation techniques. For example, knowing the incubation period of a given disease, they had a sound basis for setting the number of days required for quarantine. Knowing the conditions under which water or food transmitted disease, they could prescribe effective measures for control of such conditions.

This maturation continued into the early decades of the twentieth century. Beginning in the mid-1930s it was substantially augmented by still another important scientific development, this one brought to the public through the personal medical care system rather than through public health per se. This was the “antimicrobial revolution” and the development and subsequent use of antibiotics in the delivery of personal health services. Even though there had been a decline in the frequency of certain infectious diseases before the full effects of these different breakthroughs were felt, the downward trends were increased dramatically as a result of them. Due in part to these advances, as well as improvements in living standards, nutrition, and other factors, trends in overall mortality rates showed dramatic decreases.

State and local health departments became the major vehicles by which these advances in both microbial science and environmental sanitation were made available to the public. As state and local health departments began to direct their attention to the causes of death and morbidity, they broadened and refined their activities. Services were made available to the community at large whether people were sick or not. Programs and activities were developed to aid those who were considered at the greatest risk of contracting disease. For example, the first children’s bureau in a city health department was established in 1908 because of a conscien-
tious and inquiring child health inspector, Josephine Baker, M.D., who was appalled at the conditions in which pregnant mothers and their newborns lived.\textsuperscript{11}

As the nation moved into the 1900s public health departments continued to refine their activities. In 1949, the Minnesota State Department of Health became the first to employ an epidemiologist; one year later it established a division of epidemiology.\textsuperscript{12} In 1908 there were no county health departments; by 1920 there were 131.\textsuperscript{13} Gradually, the traditional American ambivalence about government interference gave way to a desire for the benefits that government intervention could provide to the public through sanitation, control of communicable disease, and other traditional public health activities.

At the same time, state and local governments were playing an increasingly important role in the delivery of personal health services. Beginning as poor houses more concerned with welfare than providing medical services, the almshouses of the 1700s and 1800s evolved in the late 1800s into city hospitals whose primary purpose was to deliver medical services. In the early 1900s, these hospitals affiliated with medical schools and acquired full-time staffs.\textsuperscript{14} Over roughly the same period, the inpatient population of state mental institutions grew to a peak of 560,000 in 1955. Now, as a result of the deinstitutionalization movement of the last twenty-five years, there are today less than 150,000 people in state mental hospitals.\textsuperscript{15} How to care properly for those who have been discharged from state institutions or are no longer admitted to them is currently a difficult and pressing policy issue.

Today, the core of our “public” delivery system is the nation’s ninety urban public hospitals owned by city or county government and forty-five state-owned university hospitals. These 135 hospitals represent roughly two-thirds of the total public hospital beds in the United States. Most of the remaining 1,770 “public” hospitals serve as essentially community hospitals and admit predominantly private patients. They tend to be smaller and located in suburban or rural areas. Combined with selected voluntary hospitals with high Medicaid and free care caseloads—usually private teaching hospitals—these 135 institutions represent the country’s true back-up delivery system for the poor.\textsuperscript{16} Though Medicaid and Medicare did enable large numbers of the poor to purchase care from private hospitals and physicians, the size and scope of state Medicaid programs varies tremendously, and the record across the country is uneven in this regard. As a result, despite the passage of Medicaid and Medicare, in many large cities these public and selected voluntary hospitals continue to play a vital role in delivering personal health services to the poor as well as to other special population groups, including alcohol and drug abusers, victims of violence, and the chronically mentally ill. Nationally, public hospitals in the nation’s 100 largest cities provide four
times as much care for the poor, as a proportion of the total care they deliver, as do private hospitals in the same cities. (See Figure 1.) On average, care for the poor—free care, bad debt, and care for Medicaid recipients—represents almost 40 percent of what public hospitals in the largest cities do. Today, ninety public general hospitals provide 13 percent of all inpatient services and 30 percent of all outpatient visits in the 100 largest cities.\(^{17}\)

### Figure 1
Care For The Poor (Medicaid, Charity Care, Bad Debt) As A Proportion Of Gross Patient Revenues By Ownership Selected Urban Hospitals, Fiscal Year 1980\(^{\text{a}}\)

![Figure 1](http://content.healthaffairs.org/)


\(^{\text{a}}\)Nonfederal, nonprofit, short-term general hospitals of 100 or more beds and located in the 100 largest cities.

Joining them are the nation’s 3,000 state and local health departments. Many health departments also offer a broad range of medical services and play a key role in providing personal medical care to the poor, especially children. For example, in 1980 almost one out of three Americans received direct services from state and local health departments.\(^{18}\) In addition to services provided by public hospitals and health departments, state and local governments also deliver services directly through other institutions, including long-term care and psychiatric facilities.

The federal health programs of the 1960s dramatically increased public expenditures for health care for the poor, chiefly through two strategies. The first strategy, Medicaid, was to provide insurance coverage so that eligible low-income persons could purchase medical services from private hospitals and physicians. However, in practice, Medicaid also substantially increased revenues available to public hospitals and health
departments. Today, Medicaid represents almost 20 percent of the revenues of public hospitals.

The second strategy was to directly increase federal support for the delivery of services by institutions that had traditionally served the poor—public hospitals and local health departments. Federal grants went to state health departments and public hospitals, and for support to programs such as maternal and infant care; children and youth projects; drug, alcohol, and family planning services; and other programs serving special population groups. These programs increased the involvement of local health departments in the delivery of medical services to the poor. In addition, the federal government directly subsidized medical services to the poor through the development of community health centers, rural and migrant health centers, community mental health centers, and other community-based delivery organizations not connected to hospitals. In all, some 1,000 such organizations were established, significantly expanding the range of public and quasi-public organizations providing health services to low-income persons.

Thus, by the 1980s, state and local governments were heavily involved both in traditional public health activities and in the delivery of personal medical care services, particularly to the poor. At the same time, the traditional state and local public health focus on sanitation and communicable disease also had expanded to include a broader range of man-made environmental concerns—air and water pollution, radiation control, hazardous waste, and occupational health and safety, though state and local health departments did not always have formal responsibility for these problems.

Government’s involvement with these environmental issues began at the local level with one of the most visible and tangible environmental problems—smoke. In Clean Air, Charles Jones describes the process by which environmental issues received national attention: “Air pollution problems were first on the agenda of local government, then states, and finally federal. Whether or not cities had scientific and technical capabilities for precise objective analysis, they had smoke, and smoke refused to stay within the urban boundaries designated by man. And whether or not smoke, soot, and offensive odors had this or that effect on health, they were obviously unpleasant to many people. Local and state governments had long had the power to control such unpleasantness, simply by declaring it a nuisance.”

Beginning with these obvious environmental concerns—Charles Dickens once described Pittsburgh as “hell with the lid lifted”—government involvement broadened to other environmental problems. This was partly a response to mounting scientific evidence of the health hazards posed by less obvious man-made environmental problems. It was also the result of a significant shift in public attitudes towards environmental protection and an accompanying shift in the thrust of domestic political activism.
that occurred in the late 1960s. Between 1965 and 1970, according to Gallup polls, air and water pollution moved from ninth to second place (just behind reducing crime) on the list of domestic problems identified by the public as requiring government action. Today the frontiers of what is appropriately “public health” are being pushed further, and there is increasing interest and activity in areas such as prevention and lifestyle and behavior change.

Finally, as Medicaid budgets grew in the 1970s, states became increasingly alarmed by their rapidly increasing expenditures for health. As a result, through certificate-of-need and rate regulation as well as various efforts to reform their Medicaid programs, several states are now in the forefront of efforts to control health care costs.

The Public Health Enterprise Today

Today, these various activities of state and local government in health are a significant part of what state and local governments do. More than one out of every six dollars states spend (16.9 percent) are devoted to health, slightly more than the share of the federal budget devoted to health, about 13 percent (See Figure 2.) (Because state-owned university hospitals are usually recorded in budget line items for higher education, the figures given here somewhat understate the total commitment made by states in health and overstate expenditures for education.) Only edu-

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**Figure 2**
Selected State And Local Government Expenditures-By Function, 1981

<table>
<thead>
<tr>
<th>Percent Distribution of State General Expenditures</th>
<th>Percent Distribution of Local Government General Expenditures</th>
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<tbody>
<tr>
<td>Education 38.2%</td>
<td>Other 14.9%</td>
</tr>
<tr>
<td>Housing and Urban Renewal .03%</td>
<td>Housing and Urban Renewal 2.7%</td>
</tr>
<tr>
<td>Environment ** 2.5%</td>
<td>Environment 8.9%</td>
</tr>
<tr>
<td>Public Safety 3.7%</td>
<td>Public Safety 9.2%</td>
</tr>
<tr>
<td>Transportation 10.4%</td>
<td>Transportation 7.3%</td>
</tr>
<tr>
<td>Public Health ** 3.1%</td>
<td>Health and Hospitals ** 7.8%</td>
</tr>
<tr>
<td>Hospitals ** 5%</td>
<td>Public Welfare * 5.6%</td>
</tr>
<tr>
<td>Health 16.8%</td>
<td>Education 43.6%</td>
</tr>
<tr>
<td>Medicaid 8.7%</td>
<td>Public Welfare *</td>
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<tr>
<td>Public Welfare * 11.5%</td>
<td></td>
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<tr>
<td>Other 16.6%</td>
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</tbody>
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*Health-related services and programs other than hospital care and financial support of health programs of other governments (county or city). Includes public health research, nursing, immunization, maternal and child health, and other categorical environmental and general health activities. Excludes vendor payments for health services administered under public welfare programs.*
cation consumes a bigger share of state funds (38.2 percent). States spend approximately 1½ times more for health than for transportation (10.4 percent) or public welfare (11.6 percent); 4½ times more than for public safety (3.7 percent); seven times more than for natural resources (2.5 percent); and fifty-six times more than for housing and urban renewal (0.3 percent). Medicaid alone represents 8.7 percent of all state expenditures. Expenditures for psychiatric, long-term care, and other institutions represent about 5 percent of total state spending. Expenditures for traditional public health activities, on the other hand, represent only 3.1 percent. In simple dollar terms, from the perspective of a state budget officer, expenditures for health care are a significant matter; expenditures for public health per se, less so.

As a proportion of their overall expenditures, local governments spend about half as much as states on health. Local governments spend 7.8 percent of their overall expenditures for health purposes, a proportion roughly equal to that of transportation (7.3 percent), somewhat more than that of public welfare (5.6 percent), and slightly less than public safety (9.2 percent) and natural resources (8.9 percent). By far the largest component of local government spending (43 percent) is for education (Figure 2).

Figure 3 shows the major component parts of state and local health dollars. Medicaid consumes 51 percent of all state and local health spending. Expenditures for state and local psychiatric, long-term care, and other institutions represent 36 percent of state and local health spending. Expenditures for public health activities represent only 13 percent of state and local spending for health—about $6 billion nationally in 1981. However, this amount represented more than 80 percent of total national expenditures for public health activities in that year. Over the past decade, state and local spending for public health has risen from about

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**Figure 3**
Components Of State And Local Health Expenditures As Percent Of Total Expenditures For Health, 1981

- Public Health: 13%
- Medicaid: 51%
- Hospitals: 36%

Source: Bureau of the Census, Governments' Finances in 1980-81, Series GF81, No. 5, (includes federal dollars)
half to now more than 80 percent of overall national expenditures for public health. Public health represents 2.5 percent of national health expenditures; personal health services represent 89 percent. In fact, the cost of administering health insurance programs (3.9 percent of national health expenditures) exceeds our total national contribution to public health. (See Figure 4.)

Figure 4
Distribution Of Selected Health Expenditures As A Percentage Of Total U.S. Health Expenditures, 1981 ($286.6 Billion)

State and local governments have organized in different ways to provide public health services. Not all state level public health services, for example, are provided by the state health department, nor are state health departments found in the same place on the organization charts of state governments. A survey of the fifty state, six territorial, and one district health agencies (SHAs) shows that these agencies fit within one of two organizational models: thirty-five are organized either as freestanding independent agencies responsible to the governor or a board of health; and twenty-two are a component of a larger super or umbrella agency.21 (The latter were developed as a means to increase program effectiveness and efficiency by putting together all the various functional divisions that perform health activities.)

The responsibilities of state health departments vary as well. For example, forty-five SHAs were designated State Crippled Children Agency; fifteen SHAs were designated State Mental Health Authority; ten SHAs were the designated Medicaid Single State Agency; thirty-three SHAs were the designated State Health Planning and Development Agency; seventeen SHAs were designated as the lead environmental
agency; and twenty-four SHAs operated hospitals or other health care institutions. In 1981, state agencies spent $4.85 billion, providing services in four broad budget areas related to public health: (1) personal health; (2) environmental health; (3) health resources; and (4) public health laboratories.

State health departments provide personal health services, including services for handicapped children, maternal and child care, chronic disease care, dental health, and the purchase or direct provision of inpatient care and mental health; offer programs dealing with communicable diseases such as tuberculosis epidemiology and the control of sexually transmitted disease; provide public health nursing, nutrition, health education, and health screening services. State agencies spend the largest proportion of all of their funds for personal health services—73.5 percent in 1981.

In most states, environmental health is not the responsibility of the state health agency but of either a state environmental protection agency or natural resources agency. The Department of Environmental Protection in New Jersey, for example, is responsible for environmental quality (including air pollution, noise control, radiation protection, and pesticide control); waste management (including solid waste disposal, landfills, and hazardous waste clean-up), and water resources, coastal resources, fish, game and wildlife, and parks and forestry. This agency will spend $76 million on these activities in 1983, exclusive of any assistance it may receive for clean-up efforts through the federal “superfund.” In 1981, only fourteen state health departments were designated as the leading environmental agencies. However, in 1981, fifty-four SHAs operated some type of environmental health program providing such services as consumer protection and sanitation, water quality, air quality, waste management, radiation control, occupational health and safety, and others. Of the $323 million SHAs spent for environmental health programs in 1981, 57 percent came from state sources, 26 percent from federal grants and contracts, and the remaining 17 percent from fee income, local, and other sources. Thus, in 1981, SHAs spent almost eleven times as much on personal health services as on environmental health.

State health departments also provide a broad range of services under the rubric of “health resources.” These include health planning; the regulation of health facilities and manpower; health professions development; the development and regulation of emergency medical services; and the collection, analysis, and publication of health statistics. In 1981, fifty-five SHAs were involved in providing at least one of these services. SHAs spent $364 million in 1981 for programs in these areas.

All fifty-seven state and territorial SHAs provide laboratory services either directly or by contract. The two primary areas of laboratory programs are testing of human and animal specimens and environmental
samples, and the oversight of laboratories through the regulation and development of standards. In 1981, to detect diseases such as tuberculosis, rabies, PKU (phenylketoneuria), cancer, and sexually transmitted diseases, SHA-operated laboratories analyzed a total of 32.6 million specimens or samples; for the most part these tests were performed in support of personal health services. In addition, SHAs reviewed more than 10,563 clinical laboratories for Medicaid or Medicare certification, or for licensure, or for premartial syphiliserology.\textsuperscript{27}

Local health departments provide a similar set of services, but few local departments perform all of them. In 1981, there were some 3,071 local health departments providing services in forty-six states and one territory. Local health departments spent $2.438 billion in 1981 with $962 million of that amount provided by SHAs through intergovernmental grants.\textsuperscript{28}

Typically, local health departments have at least one full-time public health professional: a health officer, public health nurse, or sanitarian. Services usually provided by local health agencies include: public health nursing, sanitation, communicable disease control, epidemiology, health statistics and records, school health services, and home health care. Many of the larger local health departments also provide dental care, emergency medical services, animal control, alcohol and drug abuse prevention and control, laboratory services, and maternal and child health care.\textsuperscript{29}

With the exception of the area of personal health services, which consumes a larger share than of local health department funds (73.5 percent versus 50.6 percent), the activities of state and local health departments are roughly similar in terms of proportionate dollar commitments. (See Figure 5.)

Figure 5
Expenditures Of State And Local Health Agencies, Fiscal Year 1981

\[ Source: \text{Association of State and Territorial Health Officials, Public Health Agencies 1981: A Report of Their Expenditures and Activities, (Kensington, Md.: ASTHO, April 1983).} \]
Where Things Stand

Today, dwindling resources, expanding program and policy responsibility, and sharply rising costs pose a dilemma for state and local officials—how to reduce expenditures without cutting back vital public programs and services. Nowhere has this dilemma emerged more clearly than in health.

Over the last five years, the combination of the taxpayer’s revolt that began with the passage of Proposition 13, sharp cutbacks in federal aid to state and local government, and the national economic recession has left state and local government with dramatically reduced resources. In addition to imposing tax and expenditure limitations, Proposition 13 in California and similar measures in other states sent a clear message to state and local officials not to increase government spending. Following on its heels, major reductions in federal aid programs further reduced the funds available to state and local government. Prior to 1978, federal aid was the fastest growing item in state and local budgets. Between 1978 and 1982, per capita federal aid to states and localities fell by 25 percent in inflation-adjusted dollars, from $231 per capita to $174 per capita. The most severe cutbacks occurred in the first two years of the Reagan administration. From 1980 to 1982, federal aid was reduced by 20 percent from 1980 levels. A third fiscal jolt was the national economic recession which reduced state and local revenues while increasing expenditures for welfare and unemployment. Thus, early in 1983, more than half of the states were projecting budget deficits, a serious problem because all states (but one) are required by law to balance their budgets.

From 1954 to 1978, state, local, and federal expenditures rose significantly, although state and local spending rose faster than federal spending (at an average annual rate of 4.4 percent in inflation adjusted dollars). However, in 1978, state and local and federal spending patterns began to part company; federal expenditures rose somewhat more sharply (mainly due to increases in spending for defense, deficit financing, and Social Security and Medicare) while state and local spending began to decline. (See Figure 6.) The fiscal situation at the local level was similar. According to a 1982 survey, while cities projected little or no increase in revenues for that year, they projected an average 7.8 percent increase in expenditures; moreover, almost 60 percent of the cities surveyed projected deficits.

Faced with less money of their own and less federal aid, state officials now also find themselves with greater responsibility and discretion in the conduct and financing of domestic programs than at any time in the last twenty years. When President Reagan took office, he did so with the intent of introducing two changes in domestic policy with the potential to significantly affect state and local government activities in health. The
first was to substantially reduce the size of the federal budget through reductions in nondefense spending; the second was to restructure the roles of state, local, and federal government through his concept of New Federalism.

What was new about this New Federalism was the intent to significantly expand the role of the states in the domestic arena. In this respect, President Reagan’s New Federalism differed markedly from the efforts of presidents Johnson and Nixon, who also had moved to reshuffle the federal system. The programs of President Johnson’s Great Society initially channeled much of their funding through newly created, private not-for-profit community agencies. These programs won few friends among the nation’s mayors and county officials, many of whom saw their control over federal funds diminished in the earlier years of the Johnson administration and their political control challenged by these new agencies and their leaders. The entitlement programs of the Johnson era represented an end run; the architects of the Great Society trusted neither the capacities nor the inclinations of state and local officials. Subsequently, through his revenue sharing and block grant programs, President Nixon sought to reverse this trend and to placate local officials by giving local governments (cities and counties) greater control over federal dollars. When he came into office, President Reagan proposed yet a further shift in the federal balance, this time in the direction of the states. All of President
Reagan’s block grant proposals involved the payment of federal dollars directly to state governments which would in turn make allocation decisions. Forty-seven of the seventy-seven domestic programs consolidated into block grants by President Reagan had previously delivered funds directly to local governments. President Reagan sought to expand state discretion in running their Medicaid programs as well. In health, what the combination of these spending cuts and policy changes generally meant was less federal money and greater state flexibility and control.

For Medicaid, the result was somewhat less federal money and substantially greater flexibility. For the first time, federal contributions to Medicaid were directly reduced—3 percent in fiscal year 1982, 4 percent in fiscal year 1983, and 4.5 percent in fiscal year 1984. Changes in federal welfare eligibility rules also reduced the number of persons eligible for Medicaid by about 1.1 million nationally. More important than the cutbacks themselves, however, were several fundamental changes in federal Medicaid policy allowing states greater flexibility to pay hospitals differently and far less than in the past; to decide whom to cover under the optional eligibility categories of their Medicaid programs; to contract with less expensive hospitals or physicians and to limit Medicaid recipients’ freedom of choice; and to cover a variety of community-based services as alternatives to nursing home care.

The federal health block grants substantially reduced federal money without giving states as much discretion or flexibility as originally planned. The actual cuts in funding in the block grants, from 1981 to 1982 averaged 23.5 percent. (In 1983, the jobs bill added back funds to two of the block grants—$105 million to maternal and child health and $70 million to primary care. See Figure 7.)

The New Federalism consolidated twenty-one health programs into four block grants:

**Preventive Health and Health Services.** This block provides funds for a variety of public health and preventive health services for individuals and families. Consolidates: Home Health Services and Training, Health Incentive Grants, Flouridation, Rodent Control, Health Education/Risk Reduction, Hypertension, Emergency Medical Services, and Rape Crisis Counseling. (FY 83 funding authorization: $96.5 million)

**Maternal and Child Health.** This block provides funds for a variety of services for mothers and children (Title V services) and services for crippled children. Consolidates: Maternal and Child Health and Crippled Children’s Services, Supplementary Security Income Program, Hemophilia, Sudden Infant Death, Lead-Based Paint Poisoning Prevention, Genetic Diseases, and Adolescent Pregnancy. (FY 83 funding authorization: $373 million)

**Alcohol and Drug Abuse and Mental Health Services.** This block provides funds for programs that combat alcohol and drug abuse, that
provide services to the mentally ill through community mental health centers, and that promote mental health. Consolidates: Alcohol Project Grants, Drug Abuse Formula Grants, and Mental Health Services. (FY 83 funding authorization: $511 million),

**Primary Care.** This block provides funds for the delivery of primary care services to underserved populations. It contains only one previously categorical program—Community Health Centers, though legislation has been submitted to include Migrant Health Services, Black Lung Clinics, and Family Planning in the Primary Care block. (FY 83 funding authorization: $302.5 million)

The original intent of the block grants was to allow states to shift funds both among the blocks and within them. However, the legislation that emerged from Congress carried with it various statutory “strings,” including matching and maintenance of effort requirements, earmarking and a quick implementation schedule in the first year, and others that limited the real flexibility that had actually been granted. In the Preventive Health and Health Services and the Alcohol, Drug Abuse, and Mental Health blocks, the funds states could transfer was limited to no more than 7 percent of the total, and was subject to several other restrictions. In the other blocks, no such transfers were allowed at all. Similarly, states could choose to administer the Primary Care Health Services block (community health centers) themselves, but they could do so only if they provided matching funds of 20 percent in 1983 and 33 percent in 1984. The earmarking of funds was another “string” attached to some of the blocks. The Alcohol, Drug Abuse, and Mental Health block, for example, mandated that funds be split 35 percent for alcoholism and 35 percent for...
drug abuse within the block, and also mandated that states make grants
to every community mental health center within the state that had re-
ceived one in 1981. Another factor that influenced the early exercise of
flexibility under the blocks was the availability of “carry-over” funds which
extended previous funding levels into 1982, thus allowing states to post-
pone trade-off and priority decisions.

Predictably, in many states conflicts also arose between the legislative
and executive branches of state government over control of block grant
funds. In some states, such as California and Illinois, state legislatures
established special block grant oversight committees. In others, such as
West Virginia and Colorado, legislatures began to appropriate federal
funds themselves for the first time. The block grants also raised tensions
between state and local governments. A study conducted by the U.S.
Conference of Mayors reported that almost three-fourths of the nation’s
cities believed that they had been adversely affected by the block grants
and had not been adequately represented in the block grant allocation
process.36

The block grant experience thus far suggests that debates over the
balance of federalism in health have been, growing less philosophical and
more practical. The first principle in these modern era debates seems to
be money; the second, who has political control of it. Nevertheless, within
limits, the block grants did provide greater flexibility in several programs
which are at the core of the state and local government role in personal
health care and public health.

Anecdotal evidence and reports suggest that one trend that seems to
be emerging is shifting funds from smaller, more narrowly focused and
derographically targeted programs to programs that provide basic health
services on a statewide basis.37 For example, according to reports, funds
in the Maternal and Child Health block grants are being concentrated
more on statewide maternal and child health services than on programs
such as lead poisoning, sudden infant death, or adolescent pregnancy.
Similarly, in the Preventive Health block, states are reportedly favoring
emergency medical services and statewide laboratories over programs such
as rodent control, fluoridation, and health education. Some states are
also reportedly shifting funds between blocks as well. Evidently, a proc-
есс of prioritizing and allocating funds is underway. As this process unfolds,
the tension between the political pressure to spread available funds as
evenly as possible and the logic of targeting resources on areas of highest
need (for example, areas with the highest rates of infant mortality) is
likely to emerge as a central issue in block grant decisionmaking.

Thus, in 1983 state and local governments found themselves with less
money of their own, less federal money, and greater responsibility than
ever before. They also found themselves faced with sharply rising costs—
particularly in health. This is the final piece of the puzzle that now con-
In recent years, state health expenditures have been dramatically outstripping state resources, and expenditures for Medicaid have been leading the charge. (See Figure 8.) Since 1980, the state share of Medicaid has increased at a rate more than 2½ times that of state revenues and reserves. Moreover, expenditures for Medicaid have been rising faster than any other major component of state budgets. (See Figure 9.)

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**Figure 8**
State Resources As Compared To Rising Health Costs, 1980-1981

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**Figure 9**
Cumulative Percentage Increases, Of Selected State Government General Expenditures, Fiscal Years 1975-1981

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Source: Georgetown Center for Health Policy Studies, based on Bureau of Census data on state government finances, (Washington, D.C.: Georgetown University, 1983).
surprisingly, given the rate of increase and the relative importance of Medicaid in state budgets, reducing Medicaid expenditures has been far and away the top priority of state officials in the health area. The most rapidly rising component of the Medicaid budget is long-term care, with the sharpest increases occurring in institutional services for the mentally retarded. (See Table 1.) Over the past decade, Medicaid expenditures for long-term care have almost doubled. As Medicaid expenditures have leaped ahead, however, expenditures for public health have more than held their ground. Expenditures for public health represented 1.7 percent of state health spending in 1971, 2.1 percent in 1976, and 3.1 percent in 1981.

Table 1
Components Of All Medicaid Expenditures, Selected Fiscal Years 1970-1981, (billions of dollars)

<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>Total</td>
<td>$5.2</td>
<td>$13.5</td>
<td>$25.5</td>
<td>$29.7</td>
</tr>
<tr>
<td>All services</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Hospital care</td>
<td>42.9</td>
<td>34.6</td>
<td>36.7</td>
<td>35.9</td>
</tr>
<tr>
<td>Physician services</td>
<td>13.3</td>
<td>14.0</td>
<td>9.8</td>
<td>9.4</td>
</tr>
<tr>
<td>Dentist services</td>
<td>3.2</td>
<td>2.9</td>
<td>2.0</td>
<td>2.0</td>
</tr>
<tr>
<td>Other professional services</td>
<td>1.4</td>
<td>1.5</td>
<td>2.0</td>
<td>1.0</td>
</tr>
<tr>
<td>Drugs and drug sundries</td>
<td>7.9</td>
<td>6.6</td>
<td>5.5</td>
<td>5.7</td>
</tr>
<tr>
<td>Nursing home care</td>
<td>27.2</td>
<td>36.0</td>
<td>39.8</td>
<td>40.3</td>
</tr>
<tr>
<td>Other health services</td>
<td>4.1</td>
<td>4.4</td>
<td>4.3</td>
<td>5.7</td>
</tr>
</tbody>
</table>


State governments have responded to the Medicaid crunch in three ways. First, many states have opted for what might be called the conventional Medicaid cuts: reducing the number of people on the program, reducing benefits for those who are covered, and reducing payments to hospitals and physicians. Obviously, these cuts increase the burden of free care on public hospitals and some voluntary hospitals and on state and local health departments. Between 1976 and 1982, the percentage of the poor and near poor covered by Medicaid fell from 65 percent to 54 percent as a result of these and other measures. Second, some states have “nickel and dimed”—making it through the year with a combination of minor cost-saving measures, administrative changes, and the creative use of surpluses and accounting gimmicks. Third, some states have attempted fundamental reforms in their approaches to Medicaid. The most important appear to be all-payer rate-setting programs and fixed price contracting for Medicaid services. The latter involves replacing the fee-for-service system with negotiated (California) or competitively bid (Arizona) fixed price arrangements. How fixed price contracting (and its
many variations) actually works out in practice remains to be seen. Some states, of course, have opted to pursue all three approaches simultaneously. As a result of these measures, Medicaid expenditures, which rose 17.1 percent in 1981, rose only 9.6 percent in 1982.

Though governors, budget officers, and state health officials have been preoccupied with Medicaid in recent years, their attention to Medicaid has not necessarily meant that other state and local health activities have been left more open to rapid funding reallocations or changes in policy. As the block grant experience shows, each area of state and local government activity in health, from maternal and child health to fluoridation, is the responsibility of some unit of state and local government and often of some committee of a state legislature or city council as well, and is watched vigilantly by the health care professionals and community groups who have an interest in it.

Conclusion

Given the current fiscal and political environment, any major expansion of the state and local role in health over the next few years would be extraordinarily surprising. In 1982, over half the states imposed hiring ceilings and made program cuts. Another fifteen states made across-the-board spending cuts, and about half the states raised taxes—a significant development in the post-Proposition 13 era. The purpose of virtually all of these measures, including the tax increases, was to maintain program and expenditure levels, but not to increase them. More of the same is expected as we move through 1983 and into 1984. A report issued by the National Council of State Legislatures in January of 1983 concluded: ‘State fiscal conditions have seriously deteriorated since mid-1982. Indications are that in 1983 raising taxes will play a much larger part in solving budget problems than was true in 1982.” In other words, many states have already made all the major program cuts they could reasonably or quickly make.

The widening gap between needs and the resources available to meet them will force state and local health officials to make short-term targeting and priority decisions in order to maximize the use of available funds. Most of these decisions will be small rather than large ones—incremental changes rather than fundamental funding reallocations or policy shifts. Should available funds be invested in maternal and child health or in lead paint poisoning? Should Medicaid benefits be reduced or reimbursement limited instead? Should staffing or hours be reduced at one neighborhood clinic and expanded at another? Should any newly available city tax dollars be used to provide services to the mentally retarded, or, for example, to provide immunizations to children? Should limited available funds be devoted to providing flu immunizations or used to provide
home care for the elderly? In the short term, the art of public service in health at the state and local level will lie in making hard decisions of this kind. In at least one instance, state officials have apparently already met this challenge with some success. In 1982, in the midst of extraordinary Medicaid cuts nationwide, thirteen states found ways to finance limited increases in Medicaid eligibility or benefits.

In the long term, state and local officials and health professionals face two fundamental questions about what they should do in health. The first is whether state, and particularly local, government should de-emphasize their role as providers of personal health services (now more than 80 percent of the state and local health care dollar) and increase their activities in public health instead. After all, Medicaid and Medicare did enable large numbers of their former clients to access “mainstream” medical care. By the 1970s people with low incomes (and higher rates of illness) were seeing physicians and were receiving hospital care as often as those with higher incomes. According to a new national survey, in 1982, 75 percent of the poor reported that they were seeing a private physician as their usual source of care rather than going to a hospital (16 percent) or to a neighborhood health center (5 percent) for regular care. Moreover, the supply of physicians is increasing and their distribution appears to be widening. On the other hand, some twenty-one to twenty-seven million persons in the United States still lack health insurance. Another twenty-two million are on Medicaid. Public hospitals and local health departments play a critical role in delivering personal health services to these two groups. As Medicaid programs continue to be cut back, their role in providing personal health care is likely to increase rather than decrease. Then, too, public hospitals and local health departments serve special population groups—alcohol and drug abusers, the mentally ill, victims of violence, and persons who live in neighborhoods simply unable to sustain private medical arrangements. So, although arguments can be made about whether the mix of personal health services now being provided through public facilities is the right one—for example, some argue that public hospitals should trim back their tertiary care and concentrate instead on basic primary care—it would seem that any fundamental shift in the role of state and local governments as direct providers of personal medical care almost certainly should await a better economy and a future commitment to fill the gaps that still remain in health insurance coverage.

Underlying this question is another question that has occupied the health care community for years: Does personal medical care or public health have the greater effect on health itself? Some experts maintain that personal medical care has had relatively little impact on health status and that other factors, including public health, but also including lifestyle, general standard of living, and others have been more important. For
example, McKinlay and McKinlay have written: “In general, medical measures appear to have contributed little to the overall decline in mortality in the United States since about 1900 . . . .”

Others argue that medical interventions have had a major impact on health status, a view supported by a recent major study of mortality published by the Urban Institute: “The primary question underlying this study is, does greater medical care use contribute to significantly lower mortality rates? Based on estimates which hold fixed the effects of a number of sociodemographic, behavioral, and environmental factors, the answer is an unambiguous ‘Yes’. . . . A 10 percent increase in per capita medical care use is associated with about 1.5 percent decrease in mortality rates.”

Though this question is unlikely to be clearly resolved, it nevertheless is the basic issue that underlies any choices public officials might make between personal medical care and public health, as well as between the investment of public funds in any health-related area versus some other priority or choice.

The other major long-term question involves refocusing what government now does in public health. With the conquest of the great infectious diseases, perhaps state and local government should redouble their energies in the areas of man-made environmental and occupational hazards as well as the increasingly popular areas of lifestyle and behavior change. This too is a major long-term issue, and one that will be influenced greatly by the science base that is now evolving for these new public health concerns. The scientific challenge is whether public health can find a modern day analogue to the past efforts of an earlier era to improve sanitation and to control communicable disease. Can public health identify a few targets of opportunity in the environmental or lifestyle areas with potentially great payoffs in health terms and a technology or some means of intervention to realize that potential? For the short term, however, it is worth noting that any major efforts in these areas will in all likelihood require new funds. At 2.5 percent of national health expenditures, our public health enterprise is already quite modest and is already involved in each of these areas in addition to its traditional commitments to sanitation and the control of communicable disease.

Finally, there is one still broader question some would raise about the role of state and local government (and government in general) in health—namely, whether government should be in the business at all, or, to put the question in less extreme terms, whether government’s role should be substantially reduced. Normative issues aside, simple numbers provide a framework for thinking about this question. Government represents about 33 percent of the U.S. economy, approximately the same as government’s share of the Japanese economy (31.6 percent). In virtually every other developed nation, government’s share of the economy is larger and has grown faster in recent years: in Canada it is 40.1 percent; in England 44.3
percent; in West Germany 46.1 percent; in France 46.3 percent; in the Netherlands 60.4 percent; and in Sweden 63.2 percent. Moreover, the share of our economy represented by state and local government, now about 10 percent, has stayed between 10 and 11 percent for over a decade. The percent of our Gross National Product represented by state and local government expenditures for health has also remained almost constant over the last ten years, ranging from 1 percent in 1971 to 1.3 percent in 1981. In health, it would seem, the question is not whether the role of state and local government (or government in general) is too large, but whether government is doing what it should be doing, whether it is doing it as efficiently as possible, and whether it is planning adequately for a changing role in the future.

NOTES

4. Ibid., 62.
7. Ibid., 245.
10. Ibid., 335-336.
11. Ibid., 357.
12. Winslow, American Epidemiology, 78.
13. Ibid.
18. Altman and Hearn, “Public Hospitals.”
20. Ibid., 123.
22. Ibid., 483-484.

24. Ibid., 56.
25. Ibid., 57.
26. Ibid., 58.
27. Ibid., 45.
28. Ibid., 62.


33. Fensterman, Szaniszlo, and Stenberg, “Coping with Cutbacks.”


37. Ibid., 35.


